City of Greenfield
Custom HMO Essential 250
HMO Wise Max 2000 HDHP LG
Custom PPO Essential 250 National
PPO Wise Max 2000 National HDHP LG

I M P O R T A N T N U M B E R S

Member Services
(413) 787-4004
(800) 310-2835 (TTY: 711)

Health New England
One Monarch Place, Suite 1500
Springfield, MA 01144-1500

This health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see the next page for additional information.

Printed: 5/11/2020

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan **meets Minimum Creditable Coverage standards** that are in effect January 1, 2020 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE IN EFFECT JANUARY 1, 2020. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Special Programs & Discounts

Health New England
Where you matter.

At Health New England, we strongly believe that health insurance should do more than just pay for doctor's bills when you are sick. After all, we call it health insurance, not sickness insurance. We understand that more than just your own personal health goes into your overall well being. Your work-life, your home-life, your family, your play-time – all of these things factor in to how you are feeling – and ultimately, how healthy you are.

That's why in addition to the comprehensive benefits that we offer, we also provide a number of unique programs to address you and your family's wellness at every stage of life.

YOUR FAMILY...

Brighter Infant Beginnings

Welcoming a new baby is an exciting time in your life. It's also a busy one. We want to help by giving you the information you'll need to keep you and your baby healthy during your pregnancy. All expectant members receive the book, "Planning Your Pregnancy and Birth" and "Your Baby, Your Child: A Parent's Guide to Pregnancy and Early Childhood." These books are resources for parents on prenatal issues, early childhood development, and health during the first 6 years of life.

YOUR HEALTH...

Support for Your Healthy Lifestyle Choices

Wellness Reimbursement Program

There is more to staying healthy than seeing your doctor. It's up to you to make healthy choices, That's why Health New England gives you more than just coverage for your doctor visits.

Health New England will reimburse you up to $150* per family plan per calendar year towards services such as:

- Aerobic / wellness classes
- Athletic event registration fees
- Bike shares
- Community supported agriculture (CSA) or farm shares (Farms offering CSA shares of vegetables, fruits and other agricultural products can be found across the state. Find a CSA farm that works for you at massnrc.org/farmlocator/map.aspx?type=csa.)
- Fitness equipment and devices (i.e., treadmill, workout videos, fitbit)
- Golf and ski tickets
- Mindfulness classes and apps
- Nutrition classes and apps
- Personal trainer fees
- Qualifying fitness club memberships
- School and town sports
- Weight Watchers®
- Wellness and fitness apps

* New! For expenses incurred January 1, 2019 and after, the reimbursement offered will be $200 for an individual plan and $400 for a family plan, per calendar year. The $400 payment for a family plan can be split among family members on the plan. The maximum for each member on the plan is $200.

For more information about our wellness reimbursement program, contact us at (413) 787-4004 or visit: healthnewengland.org/wellness/reimbursement-programs.

Need Eyeglasses or Contact Lenses?

As a Health New England member, you and your covered family members can get up to 25% off when you buy glasses or contact lenses. For a list of participating eyewear providers, please see our Provider Directory or contact our Member Services Department.

Smoking Cessation

Health New England provides reimbursement of up to $50 to attend a smoking cessation program or hypnosis session.

Living Well with Chronic Conditions:

We offer comprehensive disease management programs that help you to learn how to take an active role in your own health and be as healthy as you can be. Our current offerings are for:

- Diabetes
- Asthma (adult and pediatric)
- Healthy Heart (coronary artery disease, CHF)
- High Risk Maternity

Each program features:

- Educational materials
- Outreach by an Integrated Case Manager from Health New England
- Individualized goal setting based on your wants/needs
- Easy action plans that help you attain the goals you set for yourself
- Solution-focused approaches to assist in removing any barriers you might have in receiving and managing your healthcare.

Best of all, all programs and resources are provided to our members free of charge!

Living Well Grocery Store Tours

Walk through the grocery store with a registered dietician! You'll learn how to read food labels, count carbohydrates, determine portion sizes, fat and cholesterol content, and much more! We offer tours throughout the year at various locations in Western Massachusetts. We also offer this exciting program in a virtual format free of charge to our members.

Preventive Care – From Cradle through Retirement

We offer a birthday card program to remind our members to seek age appropriate preventive care screenings and appointments with their primary care physician. We mail all members:

- 18-Month Birthday Card (sent to parents of 18 month old children)
- Whiz Kidz Birthday Card (sent to parents of children ages 5-12)
- Women's Health Birthday Card (sent to women age 35 and over)
- Men's Health Birthday Card (sent to men age 50 and over)

Healthy Alternatives

Health New England members are eligible for discounts through OptumHealth. OptumHealth is a health and wellness company with over 15 years of experience. Founded as American Chiropractic Network, OptumHealth has evolved into an organization that still specializes in chiropractic and physical therapy management but also offers other specialties such as acupuncture, massage therapy and nutritional counseling.

You can find information about discounted services available through OptumHealth at our website, healthnewengland.org/optumhealth.

Healthy Directions on healthnewengland.org

Log onto healthnewengland.org, click Members, go down to Wellness. and click Learn More. You will find information about preventive health guidelines, wellness, care management programs, member discounts and our newest offering - the Healthy Directions web portal, powered by WebMD. All you need is your Member ID number to log in and you will have access to:

- A comprehensive health appraisal with detailed health risk report and improvement recommendations
- Self-management tools to help you maintain or improve in such areas as:
  - Exercise
  - Nutrition
  - Smoking cessation

  - Stress management
  - Emotional health
  - Weight management
- Health trackers to help you follow your medical, health, and wellness goals
- Symptom Checker
- Health and medical information from the Healthwise® library
- Healthy recipes
- Self-help videos
- A personal health record
- Mobile integration with smart phones
- Eligible rewards programs (if applicable)

And so much more!

my.HealthNewEngland.org Makes it Easier to Manage your Healthcare

Simple language, straightforward menu options, and access from any device - smartphone, tablet or computer.

Access to your benefits

- Quickly access your recently processed medical and pharmacy claims
- View your HealthEquity health savings account or health reimbursement arrangement balances in real time (if applicable)
- Submit your wellness reimbursement online

Manage your account

- Designate other members on your plan to access claim information
- Set communications preferences and alerts
- Securely send messages to Health New England directly on the portal

HNEPlus – Enjoy Discounts at Local Businesses

These days, everyone wants to get the most for their money. That's the idea behind the HNEPlus program. Health New England members carry an ID card that provides valuable access to health insurance. With that same card and the HNEPlus program, members can also receive discounts for choosing healthy lifestyles!

By showing your ID card, you can get discounts from some area businesses – for travel, legal advice, and a host of fun activities. Savings from HNEPlus add up fast! What's more, our discount programs promote healthy lifestyle choices. So, you will look and feel better, too.

If you'd like to know more about the HNEPlus program, go to healthnewengland.org.

Plan Overview

Health New England

HMO PLAN OVERVIEW

WE'RE HERE WHEN YOU NEED US

If you're like most people, you don't think about your health insurance – until you need it. That's what we're here for. At Health New England, we work hard to make sure you get the care that you need, when you need it – from a routine checkup to emergency care.

Our plans offer all those services and more. Choose Health New England for:

Broad coverage
Predictable costs

Preventive care – periodic health exams, routine childhood immunizations, well-child care, and more – we cover it. Emergency care – anywhere in the world, any time of day – we cover it. Inpatient care – hospitalization, skilled nursing facility care, rehabilitation – we cover it. Outpatient care – surgery, diagnostic imaging, specialty services – we cover it. For all covered services, your payment responsibilities are outlined in this summary.

A PRIMARY CARE PROVIDER TO MANAGE YOUR CARE

You'll choose your own Primary Care Provider (PCP) from our directory. A PCP may be a doctor or participating nurse practitioner of internal medicine, family practice, general practice, or pediatrics. Your PCP is available 24 hours a day to coordinate your care, provide advice and direction, refer you to specialty care, and manage follow-up treatment.

You may select any PCP, except those who have notified us that they no longer accept new patients. Member Services representatives can provide up-to-date information on PCPs in your area. You can even choose a different PCP for each member of your family.

EASY ACCESS TO YOUR OB/GYN

We cover annual preventive GYN exams and related services – medically necessary evaluations and services for GYN conditions, mammograms, and maternity care. What's more – you don't need a referral! Just schedule your appointment with your in-plan doctor and go.

SIMPLICITY AND CONVENIENCE

- There are no claim forms to submit when you get care from in-plan providers.
- We don't require referrals for in-plan specialty services – although prior approval is required for a limited number of covered services.
- You have toll-free access to knowledgeable, friendly Member Services representatives who can help you understand your benefits and get the services you need.
- If you feel more comfortable speaking a language other than English, talk to one of our Spanish speaking Member Services representatives, or for other languages, take advantage of our free interpreter and translation service.

Health New England HMO & PPO** Essential Plans

Deductible **DOES NOT** Apply*

Select Office Services

- Routine Physicals
- Routine Eye Exams (1 per calendar year)
- Annual Gynecological Exam
- Routine Prenatal and Postpartum Care
- Primary Care Non-routine Visits
- Specialty Consultations
- Immunizations
- Allergy Injections
- Diabetic Testing Services

Select Radiological/Diagnostic

- Routine Mammogram (1 per calendar year)
- Prenatal Ultrasounds
- Screening Colonoscopy (1 every 5 calendar years)
- Allergy Testing
- Labwork

Select Outpatient Services

- ER***
- Behavioral Health (includes mental health and substance abuse)
- Early Intervention
- Diabetic Education
- Nutritional Counseling
- Nutritional Support
- Hospice
- Kidney Dialysis
- Chemotherapy
- Durable Medical Equipment

Deductible **DOES** Apply

Outpatient or Office Services

- X-rays
- Diagnostic Testing
- Diagnostic Imaging
- Outpatient Surgery
- Ambulance
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Cardiac Rehab
- Home Health Care
- Radiation Treatment

Inpatient Services

- Acute Care and Inpatient Rehab
- Skilled Care
- Behavioral Health (includes mental health and substance abuse)

**NOTE: If services other than those listed are performed during the visit, the services may be subject to the deductible.*
***For PPO Plans, the chart applies only to In-Plan services. All Out-of-Plan services apply to deductible.*
****exceptions: Essential Plus 2000 (LG) and Essential 3000 (SG)*

COM 3294-0318

Health New England

City of Greenfield HMO Essential 250

Summary of Benefits Chart

This chart provides a summary of key services offered by your Health New England (HNE) plan. Your member agreement has a full description of your plan's benefits and provisions. If any terms in this summary differ from those in your member agreement, the terms of the member agreement apply.

Note about Prior Approval:

Some services may require prior approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
Deductible per Year* (You must pay this amount for Covered Services before HNE will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible.)	$250 per individual/$500 per family
SAFETY NET: You are PROTECTED by an Out-of-Pocket Maximum each year.* (This is the most you pay for cost sharing on Essential Health Benefits each year before your plan begins to pay 100% of the allowed amount. Most of your costs, including your costs for prescription drugs and chiropractic care, apply to the Out-of-Pocket Maximum.)	$2,000 per individual, $4,000 per family
* This is applied on a Plan Year basis, from July 1 through June 30 of the following year.	

Benefit	**Your Cost**
Inpatient Care	
Acute Hospital Care	$0 after Deductible
Skilled Nursing Facility† (limited to 100 days per Calendar Year)	$0 after Deductible
Inpatient Rehabilitation† (limited to 60 days per Calendar Year)	$0 after Deductible
Outpatient Preventive Care	
Adult Routine Exams	$0
Well Child Care	$0
Child and Adult Routine Immunizations	$0
Routine Prenatal and Postpartum Care	$0
Routine Eye Exams (limited to one per Calendar Year)	$0
Annual Gynecological Exams (limited to one per Calendar Year)	$0
Routine Mammograms (routine mammograms limited to one per Calendar Year)	$0
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years)	$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	$0

Benefit	Your Cost
Nutritional Counseling (maximum of 4 visits per Calendar Year)	$0
Other Outpatient Care	
PCP Office Visit (Non-Routine) (Deductible may apply to some office services)	$20 Copay per visit
Specialist Office Visits (Deductible may apply to some office services)	$20 Copay per visit
Second Opinions (Deductible may apply to some office services)	$20 Copay per visit
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc	$0
Hearing Tests in a Specialist Office or Facility (other than routine screenings covered as part of your annual Routine Exam)	$20 Copay per visit after Deductible
Diabetic-Related Items:	
• Outpatient Services (Deductible may apply to some office services)	$20 Copay per visit
• Lab Services	$0
• Durable Medical Equipment†	20% Coinsurance
• Individual Diabetic Education	$20 Copay per visit
• Group Diabetic Education	$20 Copay per session
Emergency Room Care (Copay waived if admitted)	$150 Copay per visit
Diagnostic Testing	$0 after Deductible
Sleep Study†	$75 Copay after Deductible (one Copay per year; no Copay for home sleep studies)
Lab Services	$0
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$0 after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging†	$75 Copay after Deductible (maximum three Copays per year)
Outpatient Short-Term Rehabilitation Services (Limited to 60 visits per Calendar Year for physical or occupational therapy. The limit does not apply when services are provided to treat autism spectrum disorder.)	$20 Copay per visit per treatment type after Deductible
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	$25 Copay after Deductible for 1 day or 1/2 day
Early Intervention Services (Covered for children from birth to age 3.)	$0
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder†	$0
Surgical Services and Procedures in an Outpatient Facility (Some services require Prior Approval)	$0 after Deductible
Allergy Testing and Treatment	$20 Copay per visit
Allergy Injections	$0
Family Planning Services	
Office Visit (Deductible may apply to some office services)	$20 Copay per visit
Infertility Services	

Benefit	Your Cost
Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.	
Office Visit (Deductible may apply to some office services)	$20 Copay per visit
Outpatient Surgery/ Procedure	$0 after Deductible
Lab Test	$0
Inpatient Care†	$0 after Deductible
Maternity Care	
Non-Routine Prenatal and Postpartum Care	$20 Copay per visit
Delivery/Hospital Care for Mother and Child (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.)	$0 after Deductible
Dental Services	
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	$20 Copay after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$20 Copay per visit
Emergency Dental Care in an Emergency Room	$150 Copay per visit
Other Services	
Home Health Care †	$0 after Deductible
Hospice Services †	$0
Durable Medical Equipment†	20% Coinsurance
Prosthetic Limbs†	20% Coinsurance
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	$100 Copay per day after Deductible
Kidney Dialysis	$0
Nutritional Support †	$0
Cardiac Rehabilitation	$20 Copay per visit after Deductible
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. † (HNE covers one prosthesis per Calendar Year)	20% Coinsurance
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation)	$20 Copay per visit after Deductible
Hearing Aids† (Covered for Members age 21 and under. HNE covers the cost of one hearing aid per hearing impaired ear, every 36 months, up to a maximum of $2,000 for each hearing aid.)	$0 up to $2,000 per device per ear (you are responsible for all costs beyond maximum)
Human Organ Transplants and Bone Marrow Transplants †	$0 after Deductible
Behavioral Health (Includes Mental Health and Substance Abuse)	
Inpatient Services	$0 after Deductible
Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®	$20 Copay per consultation
Outpatient Services	$20 Copay per visit

PRESCRIPTION DRUG COVERAGE

Prescription Drugs (*certain drugs require Prior Approval*) Your Prescription Drug benefit covers those items described in our Formulary. Please call Member Services or visit healthnewengland.org for a copy of the Formulary.	**Copay**
At an In-Plan Pharmacy (up to a 30-day supply)	
Generic Drugs	$10
Formulary Drugs	$20
Non-Formulary Drugs	$35
Through Mail Order: (up to a 90-day supply of maintenance medication)	
Generic Drugs	$10
Formulary Drugs	$20
Non-Formulary Drugs	$35

How Your Prescription Drug Coverage Works

Health New England is committed to providing our members with access to safe and effective medications. We cover most prescription drugs and a small number of non-prescription drugs and medical supplies. Covered prescription drugs are divided into three tiers with different member copays. Copays you pay are applied toward your plan Out-of-Pocket Maximum.

The Health New England Formulary

Covered prescription drugs are divided into three tiers with different member copays.

Tier	Description	Level of Member Copay
1 - Generic	Approved by the U.S. Food and Drug Administration (FDA), Generic Drugs (Tier 1) contain the same active ingredients as brand name drugs, are just as safe and effective, and usually cost less. Health New England encourages the dispensing of generic drugs whenever possible. You pay the lowest copay for generic drugs.	Lowest
2 - Brand/ Formulary	Brand/Formulary Drugs (Tier 2) are marketed under a trademarked brand name, usually by one manufacturer, and do not have less costly generic equivalents. Brand/Formulary Drugs are selected based on a review of the relative safety, effectiveness and cost of the many FDA-approved drugs on the market. Your copay for Brand/Formulary Drugs is higher than for Generic Drugs, but lower than for Brand/Non-Formulary Drugs.	Higher than Tier 1 Lower than Tier 3
3 - Brand/ Non-Formulary	Any brand name drug that Health New England has not selected as a Brand/Formulary Drug is a Brand/Non-Formulary Drug (Tier 3). This category includes, any brand name drug that has a generic equivalent (Tier 1) or brand drugs that have formulary generic and brand alternatives. These medications are still covered, but at the highest copay level. We do not waive or reduce copays for Brand/Non-Formulary drugs.	Highest

A small list of drugs is not covered. Health New England limits coverage for some prescription drugs. Coverage limits include:

- Prior Approval: Your doctor has to request coverage from Health New England before you can get the drug.
- Quantity limits: Health New England will cover only a certain amount of the drug each month.
- Step therapy: You have to try a drug used to treat the same condition (therapeutic equivalent) before Health New England will cover the drug.

To obtain a complete list of drugs that are excluded, limited, or require prior authorization, or to obtain a copy of the Health New England Formulary listing, please call Member Services at (413) 787-4004 or (800) 310-2835 or visit healthnewengland.org.

Two easy ways to get your prescriptions…

At a Retail Pharmacy

Through our national pharmacy network, you can get medications at participating pharmacies no matter where in the country you are. Whether you're home, on vacation, or away for business or other reasons, you can fill prescriptions at any of the more than 50,000 pharmacies that participate in our national network. Participating pharmacies include CVS, Costco, Stop & Shop, Walgreens and Target.

Just show your Health New England ID card, along with your prescription or refill, and pay the applicable copay.

Through the Mail

We also offer a mail service option, in case you want to get your prescriptions through the mail - delivered to your home! Mail service is limited to those items for which a 90-day supply is appropriate. Your copays for mail service prescriptions may be different from your standard prescription copays. Each copay covers up to a 90-day supply of a prescription or refill.

- Sorry, there are some items you can't get through the mail service:
  - Any drugs for which mail service is prohibited by law; and
  - Prescriptions for which a 90-day supply may not be appropriate as determined by Health New England.
  - Injectables

C H I R O P R A C T I C S E R V I C E S

Office Visit Copay: $10	
What your plan covers	• We cover up to 12 visits per year for medically necessary chiropractic services. • When you receive services, your In-Plan chiropractor must notify OptumHealth Care Solutions. OptumHealth Care Solutions will work with your In-Plan chiropractor to determine the appropriate level of covered services to treat your condition. If your chiropractor does not notify OptumHealth Care Solutions, you will not be held financially liable for the services. • Health New England will cover your visits with an In-Plan chiropractor. A $10 copay applies for each visit. Copays you pay are applied toward your plan's Out-of-Pocket Maximum.
Exclusions	• Maintenance care (Care given to reduce the incidence or prevalence of illness, impairment, or risk factors, or to promote optimum function) • Orthotics • Services that are not medically necessary • Services with an Out-of-Plan chiropractor • Exclusions or limitations included in the Plan Explanation of Coverage
For more information or to find a provider	**On the web:** You can find information about OptumHealth participating chiropractors through our website. • Go to healthnewengland.org/provider-search • Go down to "Find a Chiropractic Provider" and click Search. **On the phone:** • Call Health New England Member Services at (413) 787-4004 or (800) 310-2835 • Call OptumHealth Care Solutions at (888) 676-7768

Plan Overview

Health New England

HMO PLAN OVERVIEW

WE'RE HERE WHEN YOU NEED US

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Our plans offer all those services and more. Choose Health New England for:

Broad coverage
Predictable costs

Preventive care – periodic health exams, routine childhood immunizations, well-child care, and more – we cover it. Emergency care – anywhere in the world, any time of day – we cover it. Inpatient care – hospitalization, skilled nursing facility care, rehabilitation – we cover it. Outpatient care – surgery, diagnostic imaging, specialty services – we cover it. For all covered services, your payment responsibilities are outlined in this summary.

A PRIMARY CARE PROVIDER TO MANAGE YOUR CARE

You'll choose your own Primary Care Provider (PCP) from our directory. A PCP may be a doctor or participating nurse practitioner of internal medicine, family practice, general practice, or pediatrics. Your PCP is available 24 hours a day to coordinate your care, provide advice and direction, refer you to specialty care, and manage follow-up treatment.

You may select any PCP, except those who have notified us that they no longer accept new patients. Member Services representatives can provide up-to-date information on PCPs in your area. You can even choose a different PCP for each member of your family.

EASY ACCESS TO YOUR OB/GYN

We cover annual preventive GYN exams and related services – medically necessary evaluations and services for GYN conditions, mammograms, and maternity care. What's more – you don't need a referral! Just schedule your appointment with your in-plan doctor and go.

SIMPLICITY AND CONVENIENCE

- There are no claim forms to submit when you get care from in-plan providers.
- We don't require referrals for in-plan specialty services – although prior approval is required for a limited number of covered services.
- You have toll-free access to knowledgeable, friendly Member Services representatives who can help you understand your benefits and get the services you need.
- If you feel more comfortable speaking a language other than English, talk to one of our Spanish speaking Member Services representatives, or for other languages, take advantage of our free interpreter and translation service.

Summary of Benefits Chart

This chart provides a summary of key services offered by your Health New England (HNE) plan. Your member agreement has a full description of your plan's benefits and provisions. If any terms in this summary differ from those in your member agreement, the terms of the member agreement apply.

Note about Prior Approval:
Some services may require prior approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
Combined Medical/Pharmacy Deductible per Year* (You must pay this amount for Covered Services before HNE will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible. If your plan includes prescription drug coverage, your prescriptions are subject to this Deductible.)	$2,000 per individual / $4,000 per family**
SAFETY NET: You are PROTECTED by an Out-of-Pocket Maximum each year.* (This is the most you pay for cost sharing each year before your plan begins to pay 100% of the allowed amount. Your Copays for prescription drugs are included in this Maximum.)	$5,000 per individual / $10,000 per family
* May be based on a Calendar Year or a Plan Year. This depends on the Group through which you enroll.	
** Once any individual on a family plan has paid $2,800 towards the family deductible, the plan will begin to pay benefits for that individual.	

Benefit	**Your Cost**
Inpatient Care	
Acute Hospital Care	$0 after Deductible
Skilled Nursing Facility† (limited to 100 days per Calendar Year)	$0 after Deductible
Inpatient Rehabilitation† (limited to 60 days per Calendar Year)	$0 after Deductible
Outpatient Preventive Care	
Adult Routine Exams	$0
Well Child Care	$0
Child and Adult Routine Immunizations	$0
Routine Prenatal and Postpartum Care	$0
Routine Eye Exams (limited to one per Calendar Year)	$0
Annual Gynecological Exams (limited to one per Calendar Year)	$0

Benefit	Your Cost
Routine Mammograms (routine mammograms limited to one per Calendar Year)	$0
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years)	$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	$0
Nutritional Counseling (limited to four visits per Calendar Year)	$0
Other Outpatient Care	
PCP Office Visit (Non-Routine)	$0 after Deductible
Specialist Office Visits	$0 after Deductible
Second Opinions	$0 after Deductible
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc	$0 after Deductible
Hearing Tests in a Specialist Office or Facility (other than routine screenings covered as part of your annual Routine Exam)	$0 after Deductible
Diabetic-Related Items:	
• Outpatient Services	$0 after Deductible
• Lab Services	$0 after Deductible
• Durable Medical Equipment†	$0 after Deductible
• Individual Diabetic Education	$0 after Deductible
• Group Diabetic Education	$0 after Deductible
Emergency Room Care (Copay waived if admitted)	$0 after Deductible
Diagnostic Testing	$0 after Deductible
Sleep Study†	$0 after Deductible
Lab Services	$0 after Deductible
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$0 after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging	$0 after Deductible
Outpatient Short-Term Rehabilitation Services (Limited to 60 visits per Calendar Year for physical or occupational therapy. The limit does not apply when services are provided to treat autism spectrum disorder.)	$0 after Deductible
Day Rehabilitation Program (limited to 15 full of half day sessions per condition per lifetime)	$0 after Deductible
Early Intervention Services (Covered for children from birth to age 3.)	$0 after Deductible
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder†	$0 after Deductible
Surgical Services and Procedures in an Outpatient Facility† (Some services require Prior Approval)	$0 after Deductible
Allergy Testing and Treatment	$0 after Deductible
Allergy Injections	$0 after Deductible
Family Planning Services	
Office Visit	$0 after Deductible

Benefit	Your Cost
Infertility Services	
Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.	
Office Visit	$0 after Deductible
Outpatient Surgery/ Procedure	$0 after Deductible
Lab Test	$0 after Deductible
Inpatient Care†	$0 after Deductible
Maternity Care	
Non-Routine Prenatal and Postpartum Care	$0 after Deductible
Delivery/Hospital Care for Mother and Child (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.)	$0 after Deductible
Dental Services	
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	$0 after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$0 after Deductible
Emergency Dental Care in an Emergency Room	$0 after Deductible
Other Services	
Home Health Care †	$0 after Deductible
Hospice Services †	$0 after Deductible
Durable Medical Equipment†	$0 after Deductible
Prosthetic Limbs†	$0 after Deductible
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	$0 after Deductible
Kidney Dialysis	$0 after Deductible
Nutritional Support †	$0 after Deductible
Cardiac Rehabilitation	$0 after Deductible
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. † (HNE covers one prosthesis per Calendar Year)	$0 after Deductible
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	$0 after Deductible
Hearing Aids† (Covered for Members age 21 and under. HNE covers the cost of one hearing aid per hearing impaired ear, every 36 months, up to a maximum of $2,000 for each hearing aid.)	$0 up to $2,000 per device per ear (you are responsible for all costs over maximum) after Deductible
Human Organ Transplants and Bone Marrow Transplants †	$0 after Deductible
Behavioral Health (Includes Mental Health and Substance Abuse)	
Inpatient Services†	$0 after Deductible
Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®	$0 after Deductible
Outpatient Services† (some services require Prior Approval)	$0 after Deductible

PRESCRIPTION DRUG COVERAGE

Prescription Drugs (*certain drugs require Prior Approval*) Your Prescription Drug benefit covers those items described in the Health New England Formulary. Please call Member Services or visit healthnewengland.org for a copy of the Formulary.	
Important Note: Prescription drugs are subject to the Combined Medical/Pharmacy deductible for this plan. See the Summary of Benefits Chart for information about this deductible.	**Copay**
At an In-Plan Pharmacy (up to a 30-day supply)	
Generic Drugs	$10
Formulary Drugs	$25
Non-Formulary Drugs	$45
Through Mail Order: (up to a 90-day supply of maintenance medication)	
Generic Drugs	$20
Formulary Drugs	$50
Non-Formulary Drugs	$135

How Your Prescription Drug Coverage Works

Health New England is committed to providing our members with access to safe and effective medications. We cover most prescription drugs and a small number of non-prescription drugs and medical supplies. Covered prescription drugs are divided into three tiers with different member copays. Copays you pay are applied toward your plan Out-of-Pocket Maximum.

The Health New England Formulary

Covered prescription drugs are divided into three tiers with different member copays.

Tier	Description	Level of Member Copay
1 - Generic	Approved by the U.S. Food and Drug Administration (FDA), Generic Drugs (Tier 1) contain the same active ingredients as brand name drugs, are just as safe and effective, and usually cost less. Health New England encourages the dispensing of generic drugs whenever possible. You pay the lowest copay for generic drugs.	Lowest
2 - Brand/ Formulary	Brand/Formulary Drugs (Tier 2) are marketed under a trademarked brand name, usually by one manufacturer, and do not have less costly generic equivalents. Brand/Formulary Drugs are selected based on a review of the relative safety, effectiveness and cost of the many FDA-approved drugs on the market. Your copay for Brand/Formulary Drugs is higher than for Generic Drugs, but lower than for Brand/Non-Formulary Drugs.	Higher than Tier 1 Lower than Tier 3
3 - Brand/ Non-Formulary	Any brand name drug that Health New England has not selected as a Brand/Formulary Drug is a Brand/Non-Formulary Drug (Tier 3). This category includes, any brand name drug that has a generic equivalent (Tier 1) or brand drugs that have formulary generic and brand alternatives. These medications are still covered, but at the highest copay level. We do not waive or reduce copays for Brand/Non-Formulary drugs.	Highest

A small list of drugs is not covered. Health New England limits coverage for some prescription drugs. Coverage limits include:

- Prior Approval: Your doctor has to request coverage from Health New England before you can get the drug.
- Quantity limits: Health New England will cover only a certain amount of the drug each month.
- Step therapy: You have to try a drug used to treat the same condition (therapeutic equivalent) before Health New England will cover the drug.

To obtain a complete list of drugs that are excluded, limited, or require prior authorization, or to obtain a copy of the Health New England Formulary listing, please call Member Services at (413) 787-4004 or (800) 310-2835 or visit healthnewengland.org.

Two easy ways to get your prescriptions…

At a Retail Pharmacy

Through our national pharmacy network, you can get medications at participating pharmacies no matter where in the country you are. Whether you're home, on vacation, or away for business or other reasons, you can fill prescriptions at any of the more than 50,000 pharmacies that participate in our national network. Participating pharmacies include CVS, Costco, Stop & Shop, Walgreens and Target.

Just show your Health New England ID card, along with your prescription or refill, and pay the applicable copay.

Through the Mail

We also offer a mail service option, in case you want to get your prescriptions through the mail - delivered to your home! Mail service is limited to those items for which a 90-day supply is appropriate. Your copays for mail service prescriptions may be different from your standard prescription copays. Each copay covers up to a 90-day supply of a prescription or refill.

- Sorry, there are some items you can't get through the mail service:
  - Any drugs for which mail service is prohibited by law; and
  - Prescriptions for which a 90-day supply may not be appropriate as determined by Health New England.
  - Injectables

C H I R O P R A C T I C S E R V I C E S

Office Visit Copay: $0	
What your plan covers	• We cover up to 12 visits per year for medically necessary chiropractic services. • When you receive services, your In-Plan chiropractor must notify OptumHealth Care Solutions. OptumHealth Care Solutions will work with your In-Plan chiropractor to determine the appropriate level of covered services to treat your condition. If your chiropractor does not notify OptumHealth Care Solutions, you will not be held financially liable for the services. • You must satisfy your Plan Deductible before the Plan will begin to cover your visits with an In-Plan chiropractor. A $0 copay applies for each visit. Copays you pay are applied toward your plan's Out-of-Pocket Maximum.
Exclusions	• Maintenance care (Care given to reduce the incidence or prevalence of illness, impairment, or risk factors, or to promote optimum function) • Orthotics • Services that are not medically necessary • Services with an Out-of-Plan chiropractor • Exclusions or limitations included in the Plan Explanation of Coverage
For more information or to find a provider	**On the web:** You can find information about OptumHealth participating chiropractors through our website. • Go to healthnewengland.org/provider-search • Go down to "Find a Chiropractic Provider" and click Search. **On the phone:** • Call Health New England Member Services at (413) 787-4004 or (800) 310-2835 • Call OptumHealth Care Solutions at (888) 676-7768

Plan Overview

Health New England
Where you matter.

Health New England

PPO PLAN OVERVIEW

ACCESS TO QUALITY CARE LOCALLY…

More than 7,700 local, independently practicing physicians as well as the area's finest hospitals are in our network. Every two years, we review our in-plan physicians' board certification, education, credentials, and experience to verify they meet quality standards.

…AND NATIONALLY

In addition to our local doctors and facilities, we have agreements with more than 330,000 doctors and 3,300 hospitals across the country through an arrangement with Private Health Care Systems (PHCS). You also have the flexibility to see providers who do not participate with Health New England or PHCS, but your costs will be higher and level of coverage will be lower.

Your payment responsibilities for Health New England providers, PHCS providers, and out-of-plan providers are described in this book.

EASY ACCESS TO YOUR OB/GYN

We cover annual preventive GYN exams and related services – medically necessary evaluations and services for GYN conditions, mammograms, and maternity care. What's more – you don't need a referral! Just schedule your appointment with your in-plan doctor and go.

SIMPLICITY AND CONVENIENCE

- There are no claim forms to submit when you get care from in-plan providers.
- We don't require referrals for in-plan specialty services – although prior approval is required for a limited number of covered services.
- You have toll-free access to knowledgeable, friendly Member Services representatives who can help you understand your benefits and get the services you need.
- If you feel more comfortable speaking a language other than English, talk to one of our Spanish speaking Member Services representatives, or for other languages, take advantage of our free interpreter and translation service.

Health New England HMO & PPO** Essential Plans

Deductible **DOES NOT** Apply*

Select Office Services

- Routine Physicals
- Routine Eye Exams (1 per calendar year)
- Annual Gynecological Exam
- Routine Prenatal and Postpartum Care
- Primary Care Non-routine Visits
- Specialty Consultations
- Immunizations
- Allergy Injections
- Diabetic Testing Services

Select Radiological/Diagnostic

- Routine Mammogram (1 per calendar year)
- Prenatal Ultrasounds
- Screening Colonoscopy (1 every 5 calendar years)
- Allergy Testing
- Labwork

Select Outpatient Services

- ER***
- Behavioral Health (includes mental health and substance abuse)
- Early Intervention
- Diabetic Education
- Nutritional Counseling
- Nutritional Support
- Hospice
- Kidney Dialysis
- Chemotherapy
- Durable Medical Equipment

Deductible **DOES** Apply

Outpatient or Office Services

- X-rays
- Diagnostic Testing
- Diagnostic Imaging
- Outpatient Surgery
- Ambulance
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Cardiac Rehab
- Home Health Care
- Radiation Treatment

Inpatient Services

- Acute Care and Inpatient Rehab
- Skilled Care
- Behavioral Health (includes mental health and substance abuse)

**NOTE: If services other than those listed are performed during the visit, the services may be subject to the deductible.*
***For PPO Plans, the chart applies only to In-Plan services. All Out-of-Plan services apply to deductible.*
****exceptions: Essential Plus 2000 (LG) and Essential 3000 (SG)*

COM 3294-0318

Health New England

City of Greenfield PPO Essential 250 National

Summary of Benefits Chart

This chart provides a summary of key services offered by your Health New England (HNE) plan. Your member agreement has a full description of your plan's benefits and provisions. If any terms in this summary differ from those in your member agreement, the terms of the member agreement apply.

Note about Prior Approval:
Some services may require prior approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan Providers HNE and PHCS Providers	**Out-of-Plan Providers**
Deductible per Year* (You must pay this amount for Covered Services before HNE will begin to pay benefits. This is a combined amount for HNE, PHCS, and Out-of-Plan providers. As indicated in the chart below, some services are not subject to the Deductible.)	$250 per individual / $1,000 per family	$250 per individual / $1,000 per family
In-Plan Out-of-Pocket Maximum* (This is the most you pay for cost sharing on Essential Health Benefits each year before your plan begins to pay 100% of the allowed amount. This is a combined amount for HNE and PHCS providers. Most of your In-Plan costs, including your costs for prescription drugs, apply to the Out-of-Pocket Maximum.)	$2,000 per individual / $4,000 per family	Not applicable
Out-of-Plan Out-of-Pocket Maximum* (This is the most you will pay in a year for the combined cost of your Medical Deductible and Coinsurance for Covered Services from Out-of-Plan Providers.)	Not applicable	$3,000 per individual / $6,000 per family
* This is applied on a Plan Year basis, from July 1 through June 30 of the following year.		
Reduction of Benefit (Applies to certain services if Prior Approval is required but not requested.)	$500 (Does not apply to HNE Providers)	$500

Benefit	**Your Cost In-Plan Providers HNE and PHCS Providers**	**Your Cost Out-Of-Plan Providers**
Inpatient Care		
Acute Hospital Care (elective admission to Out of-Plan facilities require Prior Approval)	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Skilled Nursing Facility† (limited to 100 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval)	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Inpatient Rehabilitation† (limited to 60 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval)	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit

Benefit	Your Cost In-Plan Providers HNE and PHCS Providers	Your Cost Out-Of-Plan Providers
Outpatient Preventive Care		
Adult Routine Exams	$0	20% Coinsurance after Deductible
Well Child Care	$0	20% Coinsurance after Deductible
Child and Adult Routine Immunizations	$0	20% Coinsurance after Deductible
Routine Prenatal and Postpartum Care	$0	20% Coinsurance after Deductible
Routine Eye Exams (limited to one per Calendar Year)	$0	20% Coinsurance after Deductible
Annual Gynecological Exams (limited to one per Calendar Year)	$0	20% Coinsurance after Deductible
Routine Mammograms (routine mammograms limited to one per Calendar Year)	$0	20% Coinsurance after Deductible
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years)	$0	20% Coinsurance after Deductible
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	$0	20% Coinsurance after Deductible
Nutritional Counseling (limited to four vists per Calendar Year)	$0	20% Coinsurance after Deductible
Other Outpatient Care		
Physician Office Visit (Deductible may apply to some In-Plan office services.)	$20 Copay per visit	20% Coinsurance after Deductible
Second Opinions (Deductible may apply to some In-Plan office services.)	$20 Copay per visit	20% Coinsurance after Deductible
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc	$0	Not covered
Hearing Tests in a Specialist Office or Facility (other than routine screenings covered as part of your annual Routine Exam)	$20 Copay per visit after Deductible	20% Coinsurance after Deductible
Diabetic-Related Items:		
• Outpatient Services (Deductible may apply to some In-Plan office services.)	$20 Copay per visit	20% Coinsurance after Deductible
• Lab Services	$0	20% Coinsurance after Deductible
• Durable Medical Equipment†	20% Coinsurance; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
• Individual Diabetic Education	$20 Copay per visit	20% Coinsurance after Deductible
• Group Diabetic Education	$20 Copay per session	20% Coinsurance after Deductible
Emergency Room Care (Copay waived if admitted)	$150 Copay per visit	$150 Copay per visit
Diagnostic Testing	$0 after Deductible	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers HNE and PHCS Providers	Your Cost Out-Of-Plan Providers
Sleep Study†	$75 Copay after Deductible (One Copay per year; no Copay for home sleep studies. For PHCS providers, without Prior Approval, Member pays all costs.)	20% Coinsurance after Deductible (Without Prior Approval, Member pays all costs.)
Lab Services	$0	20% Coinsurance after Deductible
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$0 after Deductible	20% Coinsurance after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging†	$75 Copay after Ded, max 3 Copays/year; PHCS providers if no Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Outpatient Short-Term Rehabilitation Services (Limited to 60 visits per Calendar Year for physical or occupational therapy. The limit does not apply when services are provided to treat autism spectrum disorder.)	$20 Copay per visit per treatment type after Deductible	20% Coinsurance after Deductible
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	$25 Copay after Deductible for 1 day or 1/2 day	20% Coinsurance after Deductible
Early Intervention Services (Covered for children from birth to age 3.)	$0	20% Coinsurance after Deductible
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder†	$0 (for PHCS providers, without Prior Approval Member pays all costs)	20% Coinsurance after Deductible (without Prior Approval Member pays all costs)
Surgical Services and Procedures in an Outpatient Facility† (Some services require Prior Approval)	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Allergy Testing and Treatment	$20 Copay per visit	20% Coinsurance after Deductible
Allergy Injections	$0	20% Coinsurance after Deductible
Family Planning Services		
Office Visit (Deductible may apply to some In-Plan office services)	$20 Copay per visit	20% Coinsurance after Deductible
Infertility Services		
Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.		
Office Visit (Deductible may apply to some In-Plan office services)	$20 Copay per visit; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible: without Prior Approval, Member pays all costs
Outpatient Surgery/ Procedure	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible: without Prior Approval, Member pays all costs

Benefit	Your Cost In-Plan Providers HNE and PHCS Providers	Your Cost Out-Of-Plan Providers
Lab Test	$0; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible: without Prior Approval, Member pays all costs
Inpatient Care†	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible: without Prior Approval, Member pays all costs
Maternity Care		
Non-Routine Prenatal and Postpartum Care	$20 Copay per visit	20% Coinsurance after Deductible
Delivery/Hospital Care for Mother and Child† (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.)	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Dental Services		
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	$20 Copay after Deductible	20% Coinsurance after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$20 Copay per visit	20% Coinsurance after Deductible
Emergency Dental Care in an Emergency Room	$150 Copay per visit	$150 Copay per visit
Other Services		
Home Health Care †	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Hospice Services †	$0; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Durable Medical Equipment†	20% Coinsurance; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Prosthetic Limbs†	20% Coinsurance; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval; if Prior Approval is not obtained for non-emergency transportation, Member pays all costs)	$100 Copay per day after Deductible	$100 Copay per day after Deductible
Kidney Dialysis	$0	20% Coinsurance after Deductible
Nutritional Support † (not covered without Prior Approval)	$0	$0
Cardiac Rehabilitation	$20 Copay per visit after Deductible	20% Coinsurance after Deductible
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. † (HNE covers one prosthesis per Calendar Year)	20% Coinsurance	20% Coinsurance

Benefit	Your Cost In-Plan Providers HNE and PHCS Providers	Your Cost Out-Of-Plan Providers
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	$20 Copay per visit after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Hearing Aids† (Covered for Members age 21 and under. HNE covers the cost of one hearing aid per hearing impaired ear, every 36 months, up to a maximum of $2,000 for each hearing aid.)	$0 up to $2,000 per device per ear; for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible (Without Prior Approval Member pays all costs)
Human Organ Transplants and Bone Marrow Transplants † (Without Prior Approval, payments you make to Out-of-Plan Providers for Deductible and Coinsurance do not count toward your Deductible or Maximum Coinsurance amounts.)	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Behavioral Health (Includes Mental Health and Substance Abuse)		
Inpatient Services†	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®	$20 Copay per consultation	Not covered
Outpatient Services† (some services require Prior Approval)	$20 Copay per visit	20% Coinsurance after Deductible

PRESCRIPTION DRUG COVERAGE

Prescription Drugs (*certain drugs require Prior Approval*)

Your Prescription Drug benefit covers those items described in the Health New England Formulary.

Please call Member Services or visit healthnewengland.org for a copy of the Health New England Formulary.

	Copay In-Plan Provider	**Copay Out-of-Plan Provider**
At an In-Plan Pharmacy (up to a 30-day supply)		
Generic Drugs	$10	$10 copay, then 20%
Formulary Drugs	$20	$20 copay, then 20%
Non-Formulary Drugs	$35	$35 copay, then 20%
Through Mail Order: (up to a 90-day supply of maintenance medication)		
Generic Drugs	$10	Not Covered
Formulary Drugs	$20	Not Covered
Non-Formulary Drugs	$35	Not Covered

How Your Prescription Drug Coverage Works

Health New England is committed to providing our members with access to safe and effective medications. We cover most prescription drugs and a small number of non-prescription drugs and medical supplies. Covered prescription drugs are divided into three tiers with different member copays. Copays you pay for prescription drugs from In-Plan providers are applied toward your In-Plan Out-of-Pocket Maximum.

The Health New England Formulary

Covered prescription drugs are divided into three tiers with different member copays.

Tier	Description	Level of Member Copay
1 - Generic	Approved by the U.S. Food and Drug Administration (FDA), Generic Drugs (Tier 1) contain the same active ingredients as brand name drugs, are just as safe and effective, and usually cost less. Health New England encourages the dispensing of generic drugs whenever possible. You pay the lowest copay for generic drugs.	Lowest
2 - Brand/ Formulary	Brand/Formulary Drugs (Tier 2) are marketed under a trademarked brand name, usually by one manufacturer, and do not have less costly generic equivalents. Brand/Formulary Drugs are selected based on a review of the relative safety, effectiveness and cost of the many FDA-approved drugs on the market. Your copay for Brand/Formulary Drugs is higher than for Generic Drugs, but lower than for Brand/Non-Formulary Drugs.	Higher than Tier 1 Lower than Tier 3
3 - Brand/ Non-Formulary	Any brand name drug that Health New England has not selected as a Brand/Formulary Drug is a Brand/Non-Formulary Drug (Tier 3). This category includes, any brand name drug that has a generic equivalent (Tier 1) or brand drugs that have formulary generic and brand alternatives. These medications are still covered, but at the highest copay level. We do not waive or reduce copays for Brand/Non-Formulary drugs.	Highest

A small list of drugs is not covered. Health New England limits coverage for some prescription drugs. Coverage limits include:

- Prior Approval: Your doctor has to request coverage from Health New England before you can get the drug.
- Quantity limits: Health New England will cover only a certain amount of the drug each month.
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Two easy ways to get your prescriptions…

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Just show your Health New England ID card, along with your prescription or refill, and pay the applicable copay.

Through the Mail

We also offer a mail service option, in case you want to get your prescriptions through the mail - delivered to your home! Mail service is limited to those items for which a 90-day supply is appropriate. Your copays for mail service prescriptions may be different from your standard prescription copays. Each copay covers up to a 90-day supply of a prescription or refill.

- Sorry, there are some items you can't get through the mail service:
  - Any drugs for which mail service is prohibited by law; and
  - Prescriptions for which a 90-day supply may not be appropriate as determined by Health New England.
  - Injectables

C H I R O P R A C T I C S E R V I C E S

Office Visit Copay: $10	
What your plan covers	• We cover up to 12 visits per year for medically necessary chiropractic services.
In-Plan Option	• When you receive services, your In-Plan chiropractor must notify OptumHealth Care Solutions. OptumHealth Care Solutions will work with your In-Plan chiropractor to determine the appropriate level of covered services to treat your condition. If your chiropractor does not notify OptumHealth Care Solutions, you will not be held financially liable for the services. • Health New England will cover your visits with an In-Plan chiropractor. A $10 copay applies for each visit. Copays you pay for In-plan chiropractic services are applied toward your plan's In-Plan Out-of-Pocket Maximum.

Out-of-Plan Option	• You may visit any chiropractor, but your level of coverage will be higher and costs lower when you use In-Plan providers.
	• When you use Out-of-Plan providers:
	  • You pay your copay. After you pay your copay, OptumHealth Care Solutions will pay 80 percent of its maximum allowable fee. You are responsible for any remaining balance. Your payments for Copays and Coinsurance are applied to your plan's Out-of-Plan Out-of-Pocket Maximum.
	  • After you receive services from an Out-of-Plan chiropractor, OptumHealth Care Solutions may review claims information submitted for those services. Then, OptumHealth Care Solutions will work with your Out-of-Plan chiropractor to determine the appropriate level of covered services to treat your condition.

Exclusions	• Maintenance care (Care given to reduce the incidence or prevalence of illness, impairment, or risk factors, or to promote optimum function) • Orthotics • Services that are not medically necessary • Exclusions or limitations included in the Plan Explanation of Coverage
For more information or to find a provider	**On the web:** You can find information about OptumHealth participating chiropractors through our website. • Go to healthnewengland.org/provider-search • Go down to "Find a Chiropractic Provider" and click Search. **On the phone:** • Call Health New England Member Services at (413) 787-4004 or (800) 310-2835 • Call OptumHealth Care Solutions at (888) 676-7768

Plan Overview

Health New England

PPO PLAN OVERVIEW

ACCESS TO QUALITY CARE LOCALLY…

More than 7,700 local, independently practicing physicians as well as the area's finest hospitals are in our network. Every two years, we review our in-plan physicians' board certification, education, credentials, and experience to verify they meet quality standards.

…AND NATIONALLY

In addition to our local doctors and facilities, we have agreements with more than 330,000 doctors and 3,300 hospitals across the country through an arrangement with Private Health Care Systems (PHCS). You also have the flexibility to see providers who do not participate with Health New England or PHCS, but your costs will be higher and level of coverage will be lower.

Your payment responsibilities for Health New England providers, PHCS providers, and out-of-plan providers are described in this book.

EASY ACCESS TO YOUR OB/GYN

We cover annual preventive GYN exams and related services – medically necessary evaluations and services for GYN conditions, mammograms, and maternity care. What's more – you don't need a referral! Just schedule your appointment with your in-plan doctor and go.

SIMPLICITY AND CONVENIENCE

- There are no claim forms to submit when you get care from in-plan providers.
- We don't require referrals for in-plan specialty services – although prior approval is required for a limited number of covered services.
- You have toll-free access to knowledgeable, friendly Member Services representatives who can help you understand your benefits and get the services you need.
- If you feel more comfortable speaking a language other than English, talk to one of our Spanish speaking Member Services representatives, or for other languages, take advantage of our free interpreter and translation service.

PPO Wise Max 2000 National HDHP LG

Summary of Benefits Chart

This chart provides a summary of key services offered by your Health New England (HNE) plan. Your member agreement has a full description of your plan's benefits and provisions. If any terms in this summary differ from those in your member agreement, the terms of the member agreement apply.

Note about Prior Approval:
Some services may require prior approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan Providers HNE and PHCS	**Out-of-Plan Providers**
Combined Medical/Pharmacy Deductible per Year* (You must pay this amount for Covered Services before HNE will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible. If your plan includes prescription drug coverage, your prescriptions are subject to this Deductible. This amount is a combined amount for In-Plan & Out-of-Plan Providers.)	$2,000 per individual / $4,000 per family**	$2,000 per individual / $4,000 per family**
In-Plan Out-of-Pocket Maximum* (This is the most you pay for cost sharing each year before your plan begins to pay 100% of the allowed amount. This is a combined amount for HNE and PHCS providers. Your Copays for prescription drugs are included in this Maximum.)	$5,000 per individual / $10,000 per family	Not applicable
Out-of-Plan Out-of-Pocket Maximum* (This is the most you will pay in a year for the combined cost of your Medical/Pharmacy Deductible amount applied to Out-of-Plan services, and Coinsurance for Covered Services from Out-of-Plan Providers. Your Copays for prescription drugs are included in this Maximum.)	Not applicable	$7,500 per individual / $15,000 per family
* May be based on a Calendar Year or a Plan Year. This depends on the Group through which you enroll.		
** Once any individual on a family plan has paid $2,800 towards the family deductible, the plan will begin to pay benefits for that individual.		
Reduction of Benefit (Applies to certain services if Prior Approval is required but not requested.)	$1,000 (Does not apply to HNE Providers)	$1,000

Benefit	Your Cost In-Plan Providers HNE and PHCS	Your Cost Out-of-Plan Providers
Inpatient Care		
Acute Hospital Care (elective admissions to Out-of-Plan facilities require Prior Approval)	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Skilled Nursing Facility† (limited to 100 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval)	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Inpatient Rehabilitation† (limited to 60 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval)	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Outpatient Preventive Care		
Adult Routine Exams	$0	20% Coinsurance after Deductible
Well Child Care	$0	20% Coinsurance after Deductible
Child and Adult Routine Immunizations	$0	20% Coinsurance after Deductible
Routine Prenatal and Postpartum Care	$0	20% Coinsurance after Deductible
Routine Eye Exams (limited to one per Calendar Year)	$0	20% Coinsurance after Deductible
Annual Gynecological Exams (limited to one per Calendar Year)	$0	20% Coinsurance after Deductible
Routine Mammograms (routine mammograms limited to one per Calendar Year)	$0	20% Coinsurance after Deductible
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years)	$0	20% Coinsurance after Deductible
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	$0	20% Coinsurance after Deductible
Nutritional Counseling (limited to four visits per Calendar Year)	$0	20% Coinsurance after Deductible
Other Outpatient Care		
Physician Office Visit	$0 after Deductible	20% Coinsurance after Deductible
Second Opinions	$0 after Deductible	20% Coinsurance after Deductible
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc	$0 after Deductible	Not covered
Hearing Tests in a Specialist Office or Facility (other than routine screenings covered as part of your annual Routine Exam)	$0 after Deductible	20% Coinsurance after Deductible
Diabetic-Related Items:		
• Outpatient Services	$0 after Deductible	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers HNE and PHCS	Your Cost Out-of-Plan Providers
• Lab Services	$0 after Deductible	20% Coinsurance after Deductible
• Durable Medical Equipment†	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
• Individual Diabetic Education	$0 after Deductible	20% Coinsurance after Deductible
• Group Diabetic Education	$0 after Deductible	20% Coinsurance after Deductible
Emergency Room Care (Copay waived if admitted)	$0 after Deductible	$0 after Deductible
Diagnostic Testing	$0 after Deductible	20% Coinsurance after Deductible
Sleep Study†	$0 after Deductible; and for PHCS providers, without Prior Approval, Member pays all costs)	20% Coinsurance after Deductible (without Prior Approval Member pays all costs)
Lab Services	$0 after Deductible	20% Coinsurance after Deductible
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$0 after Deductible	20% Coinsurance after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging†	$0 after Deductible; and for PCHS providers without Prior Approval, Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Outpatient Short-Term Rehabilitation Services (Limited to 60 visits per Calendar Year for physical or occupational therapy. The limit does not apply when services are provided to treat autism spectrum disorder.)	$0 after Deductible	20% Coinsurance after Deductible
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	$0 after Deductible	20% Coinsurance after Deductible
Early Intervention Services (Covered for children from birth to age 3.)	$0 after Deductible	20% Coinsurance after Deductible
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder†	$0 after Deductible (for PHCS Providers, without Prior Approval Member pays all costs)	20% Coinsurance after Deductible (without Prior Approval Member pays all costs)
Surgical Services and Procedures in an Outpatient Facility† (Some services require Prior Approval)	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Allergy Testing and Treatment	$0 after Deductible	20% Coinsurance after Deductible
Allergy Injections	$0 after Deductible	20% Coinsurance after Deductible
Family Planning Services		
Office Visit	$0 after Deductible	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers HNE and PHCS	Your Cost Out-of-Plan Providers
Infertility Services		
Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.		
Office Visit	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Outpatient Surgery/ Procedure	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Lab Test	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Inpatient Care†	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Maternity Care		
Non-Routine Prenatal and Postpartum Care	$0 after Deductible	20% Coinsurance after Deductible
Delivery/Hospital Care for Mother and Child† (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.)	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Dental Services		
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	$0 after Deductible	20% Coinsurance after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$0 after Deductible	20% Coinsurance after Deductible
Emergency Dental Care in an Emergency Room	$0 after Deductible	$0 after Deductible
Other Services		
Home Health Care †	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Hospice Services †	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Durable Medical Equipment†	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Prosthetic Limbs†	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs

Benefit	Your Cost In-Plan Providers HNE and PHCS	Your Cost Out-of-Plan Providers
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval; If Prior Approval is not obtained for non-emergency transportation, Member pays all costs)	$0 after Deductible	$0 after Deductible
Kidney Dialysis	$0 after Deductible	20% Coinsurance after Deductible
Nutritional Support † (not covered without Prior Approval)	$0 after Deductible	20% Coinsurance after Deductible
Cardiac Rehabilitation	$0 after Deductible	20% Coinsurance after Deductible
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. † (HNE covers one prosthesis per Calendar Year)	$0 after Deductible	20% Coinsurance after Deductible
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Hearing Aids† (Covered for Members age 21 and under. HNE covers the cost of one hearing aid per hearing impaired ear, every 36 months, up to a maximum of $2,000 for each hearing aid.)	$0 up to $2,000 per device per ear; for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible (Without Prior Approval Member pays all costs)
Human Organ Transplants and Bone Marrow Transplants † (Without Prior Approval, payments you make to Out-of-Plan Providers for Deductible and Coinsurance do not count toward your Deductible or Maximum Coinsurance amounts.)	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Behavioral Health (Includes Mental Health and Substance Abuse)		
Inpatient Services†	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible up to $1,000 Reduction of Benefit
Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®	$0 after Deductible	Not covered
Outpatient Services† (some services require Prior Approval)	$0 after Deductible	20% Coinsurance after Deductible

PRESCRIPTION DRUG COVERAGE

Prescription Drugs (*certain drugs require Prior Approval*)

Your Prescription Drug benefit covers those items described in the Health New England Formulary.

Please call Member Services or visit healthnewengland.org for a copy of the Formulary.

Important Note: Prescription drugs are subject to the Combined Medical/Pharmacy deductible for this plan. See the Summary of Benefits Chart for information about this deductible.	**Copay HNE's National Pharmacy Network**	**Copay Outside of HNE's National Pharmacy Network**
At an In-Plan Pharmacy (up to a 30-day supply)		
Generic Drugs	$10	$10 copay, then 20%
Formulary Drugs	$25	$25 copay, then 20%
Non-Formulary Drugs	$45	$45 copay, then 20%
Through Mail Order: (up to a 90-day supply of maintenance medication)		
Generic Drugs	$20	Not Covered
Formulary Drugs	$50	Not Covered
Non-Formulary Drugs	$135	Not Covered

How Your Prescription Drug Coverage Works

Health New England is committed to providing our members with access to safe and effective medications. We cover most prescription drugs and a small number of non-prescription drugs and medical supplies. Covered prescription drugs are divided into three tiers with different member copays. Copays you pay are applied toward your plan Out-of-Pocket Maximums.

The Health New England Formulary

Covered prescription drugs are divided into three tiers with different member copays.

Tier	Description	Level of Member Copay
1 - Generic	Approved by the U.S. Food and Drug Administration (FDA), Generic Drugs (Tier 1) contain the same active ingredients as brand name drugs, are just as safe and effective, and usually cost less. Health New England encourages the dispensing of generic drugs whenever possible. You pay the lowest copay for generic drugs.	Lowest
2 - Brand/ Formulary	Brand/Formulary Drugs (Tier 2) are marketed under a trademarked brand name, usually by one manufacturer, and do not have less costly generic equivalents. Brand/Formulary Drugs are selected based on a review of the relative safety, effectiveness and cost of the many FDA-approved drugs on the market. Your copay for Brand/Formulary Drugs is higher than for Generic Drugs, but lower than for Brand/Non-Formulary Drugs.	Higher than Tier 1 Lower than Tier 3
3 - Brand/ Non-Formulary	Any brand name drug that Health New England has not selected as a Brand/Formulary Drug is a Brand/Non-Formulary Drug (Tier 3). This category includes, any brand name drug that has a generic equivalent (Tier 1) or brand drugs that have formulary generic and brand alternatives. These medications are still covered, but at the highest copay level. We do not waive or reduce copays for Brand/Non-Formulary drugs.	Highest

A small list of drugs is not covered. Health New England limits coverage for some prescription drugs. Coverage limits include:

- Prior Approval: Your doctor has to request coverage from Health New England before you can get the drug.
- Quantity limits: Health New England will cover only a certain amount of the drug each month.
- Step therapy: You have to try a drug used to treat the same condition (therapeutic equivalent) before Health New England will cover the drug.

To obtain a complete list of drugs that are excluded, limited, or require prior authorization, or to obtain a copy of the Health New England Formulary listing, please call Member Services at (413) 787-4004 or (800) 310-2835 or visit healthnewengland.org.

Two easy ways to get your prescriptions…

At a Retail Pharmacy

Through our national pharmacy network, you can get medications at participating pharmacies no matter where in the country you are. Whether you're home, on vacation, or away for business or other reasons, you can fill prescriptions at any of the more than 50,000 pharmacies that participate in our national network. Participating pharmacies include CVS, Costco, Stop & Shop, Walgreens and Target.

Just show your Health New England ID card, along with your prescription or refill, and pay the applicable copay.

Through the Mail

We also offer a mail service option, in case you want to get your prescriptions through the mail - delivered to your home! Mail service is limited to those items for which a 90-day supply is appropriate. Your copays for mail service prescriptions may be different from your standard prescription copays. Each copay covers up to a 90-day supply of a prescription or refill.

- Sorry, there are some items you can't get through the mail service:
  - Any drugs for which mail service is prohibited by law; and
  - Prescriptions for which a 90-day supply may not be appropriate as determined by Health New England.
  - Injectables

CHIROPRACTIC SERVICES

Office Visit Copay: $0	
What your plan covers	• We cover up to 12 visits per year for medically necessary chiropractic services.
In-Plan Option	• When you receive services, your In-Plan chiropractor must notify OptumHealth Care Solutions. OptumHealth Care Solutions will work with your In-Plan chiropractor to determine the appropriate level of covered services to treat your condition. If your chiropractor does not notify OptumHealth Care Solutions, you will not be held financially liable for the services. • You must satisfy your Plan Deductible before the Plan will begin to cover your visits with an In-Plan chiropractor. After you have met your Deductible, a $0 copay applies for each visit.

Out-of-Plan Option	• You may visit any chiropractor, but your level of coverage will be higher and costs lower when you use In-Plan providers.
	• When you use Out-of-Plan providers:
	  • You must satisfy your Plan Deductible before the Plan will begin to cover your visits with an Out-of-Plan chiropractor. You pay your copay. After you pay your copay, OptumHealth Care Solutions will pay 80 percent of its maximum allowable fee. You are responsible for any remaining balance. Your payments for Copays and Coinsurance are applied to your plan's Out-of-Pocket Maximum.
	  • After you receive services from an Out-of-Plan chiropractor, OptumHealth Care Solutions may review claims information submitted for those services. Then, OptumHealth Care Solutions will work with your Out-of-Plan chiropractor to determine the appropriate level of covered services to treat your condition.

Exclusions	• Maintenance care (Care given to reduce the incidence or prevalence of illness, impairment, or risk factors, or to promote optimum function) • Orthotics • Services that are not medically necessary • Exclusions or limitations included in the Plan Explanation of Coverage
For more information or to find a provider	**On the web:** You can find information about OptumHealth participating chiropractors through our website. • Go to healthnewengland.org/provider-search • Go down to "Find a Chiropractic Provider" and click Search. **On the phone:** • Call Health New England Member Services at (413) 787-4004 or (800) 310-2835 • Call OptumHealth Care Solutions at (888) 676-7768

Important Notes

Health New England
Where you matter.

What if I decline coverage now – can I get it later? (Special Enrollment Rights)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you, may in the future, be able to enroll within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

How do I get Urgent Care?

We require doctor's offices to have 24 hour phone coverage. Your doctor or someone covering will help you decide what to do – whether you should get care right away or wait to see your own doctor.

Health New England also has a 24-hour nurse line. If you can't reach your doctor, call us at (413) 787-4000 or toll free (800) 842-4464. An experienced nurse will listen to your concerns and help you choose the care that's right for you.

Finally, we contract with a number of Urgent Care Centers. You can find an Urgent Care Center near you on our website, healthnewengland.org. Just click on Find a Provider at the top of the page. In general, Urgent Care Centers have a Specialist copay, not an ER copay, so you'll save time AND money. Please coordinate any follow up visits with your Primary Care Physician.

How do I get covered Durable Medical Equipment and supplies?

When prescribed by your physician, we cover certain Durable Medical Equipment (DME), medical and surgical supplies, and prostheses. Some items require Prior Approval. For HMO Plans, an In-Plan DME vendor must provide covered services. For a list of In-Plan DME vendors, please visit our website, healthnewengland.org. Then click Find a Doctor at the top of the page. If your previous insurance has been covering your supplies, please call Health New England Member Services to ensure a smooth transition.

What services are not covered by Health New England?

We cover services that are medically necessary for the prevention or treatment of illnesses or injury – as long as you follow Plan procedures. Here are some general exclusions that you should know about.

- If you have an HMO plan, care by out-of-plan providers is not covered unless it's emergency care or it's pre-authorized by the Plan.
- A small number of services require prior approval by the Plan (see the description of Utilization Management). If you sign up for an HMO plan, and you don't get prior approval for a service that requires it, we will not cover that service. For PPO plans, coverage for that service may be either denied or reduced, depending on the type of service.

- We do not cover:
  - Care or treatment provided by a family member
  - Cosmetic surgery or procedures
  - Custodial care
  - Dental services, except as described in the Summary of Benefits.
  - Educational services or testing
  - Experimental or investigational medical services
  - Holistic treatments
  - Services for the personal comfort or convenience of the member
  - Services required by third parties *(e.g., school, camp, work physical)*
  - Services that should be covered by another insurer *(like Workers' Compensation)*
  - Veterans Administration services for service-connected disabilities

Your membership materials will include a more complete listing of specific benefits, exclusions and limitations.

Important Note: *By enrolling in the Plan, or receiving benefits or coverage under the plan, you agree to accept all of the plan terms, which we describe in your member agreement.*

UTILIZATION MANAGEMENT

At Health New England, we believe that medical decisions should be made by you and your doctor.

Like any insurer, we do have coverage requirements – such as, you need to get prior approval to see a doctor who is not part of your plan. Coverage decisions are made based on all the available information, and if necessary, discussed with your doctor.

This is an important part of our Utilization Management (UM) Program.

Purpose

Through this program, we gather information on treatment and services and review certain claims. In this way, we determine if the services are ***covered benefits*** and whether treatment and services are ***medically necessary*** and ***appropriate***. Our medical director oversees the process and supervises all activities.

How it Works

We use nationally recognized guidelines and resources which measure the intensity of service along with the severity of illness or disease. If we let other provider groups perform UM functions, we approve any criteria they use. In all cases, we base decisions on whether treatment and services are medically necessary and appropriate.

Our evaluation involves a number of components:

- ***Pre-certification / Pre-authorization*** - We collect information from doctors and members before they begin an inpatient hospital stay or undergo certain outpatient procedures and services. This allows us to determine eligibility and coverage in advance and establish open, honest communications with members and their doctors. It also makes it easier to coordinate transition to the next level of care. For example, we may elect to move members into programs for chronic diseases such as asthma; register them for a prenatal program; or, initiate case management for complex situations. We make this decision based on the information available at the time service is requested.
- ***Concurrent review*** - We speak with providers and facilities to help determine whether services are covered and medically necessary; identify case management opportunities; and, begin to plan discharge.
- ***Discharge planning*** - We help coordinate a member's transition from the inpatient setting to the next level of care.
- ***Retrospective review*** - After members have received care, we may speak with providers and facilities to determine whether services are covered and medically necessary. We base our determination on whether members received treatment and services appropriate for their needs at the time of service.

Making the Decision

If we determine that a service is not covered or medically necessary, coverage for the service could be denied. Only our medical directors make decisions to deny coverage for reasons of medical necessity. We notify members and providers in writing and include information about the reasons for the determination (including the clinical rationale); how to initiate an appeal; and the clinical review criteria used in the decision.

Health New England does not:

- pay employees, providers, or others involved in utilization management for denials of coverage or service
- use incentives to reward inappropriate restrictions of care

HOW WE PROTECT YOUR PRIVACY

Health New England is committed to protecting your privacy. We keep members' protected health information (PHI) confidential according to our policies and state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA). Our Notice of Privacy Practices contains more detailed information about our policies and practices regarding the collection, use, and disclosure of your PHI. It also sets forth your rights with respect to your PHI. You can request a complete copy of our Notice of Privacy Practices by contacting Health New England Member Services.

How does Health New England protect my PHI?

We have a detailed policy on confidentiality. This policy applies to all oral, written, and electronic information that we have about you. All Health New England employees are required to protect the confidentiality of your PHI. An employee may only access, use, or disclose your information when he or she has an appropriate reason to do so. Each employee or temporary employee must sign a statement that he or she has read and understands the policy. Once a year, we send a notice to employees to remind them of this policy. Any employee who violates the policy is subject to discipline and may be fired. You may request a copy of our Privacy Policy from Health New England Member Services. We also include confidentiality provisions in all of its contracts with Plan Providers. Finally, we maintain physical, electronic, and procedural safeguards to protect your information.

How does Health New England use and disclose my PHI?

HIPAA and other laws allow or require us to use or disclose your PHI for many different reasons. Health New England may use and disclose your information in connection with your treatment, the payment for your health care, and our health care operations, including our quality and utilization management activities. We also can disclose your information to providers and other health plans that have a relationship with you for their treatment, payment and some limited health care operations. In addition, federal law allows or requires us to use or disclose your PHI to serve other purposes, such as for public health activities, or when we are required by law to disclose the information. We do not need your authorization for these purposes.

For other uses and disclosures of your information, we must get your written authorization. A written authorization request will specify the purpose of the requested disclosure, the persons or class of persons to whom the information may be given, and an expiration date for the authorization. If you do provide a written authorization, you generally have the right to revoke it.

Will Health New England disclose my PHI to anyone outside Health New England?

We may share your PHI with affiliates and third party "business associates" (such as consultants and auditors) that perform various activities for us. Whenever such an arrangement involves the use or disclosure of your PHI, we will have a written contract that contains the terms designed to protect the privacy of your PHI.

Will Health New England disclose my PHI to my employer?

In general, we will release to your employer only enrollment and disenrollment information, information that has been de-identified so that your employer cannot identify you, or summary health information. If your employer would like more specific PHI about you to perform plan administrative functions, we will either get your written authorization or we will ask your employer to certify that they have established procedures in their group health plan for protecting your PHI.

Can I get a copy of my medical records?

Health New England does not provide medical care. Members receive care and treatment from providers based in their own facilities. Under Massachusetts law, you have a right to obtain a copy

of your medical records. To obtain a copy, contact your health care provider directly.

You also have the right to see and get a copy of some of the records that Health New England maintains, such as your enrollment, payment, claims, case or medical management records, and any other records that we use to make decisions about you. Requests for access to copies of these records must be in writing and sent to the Health New England Legal Department. Please provide us with the specific information we need to fulfill your request. We may charge a reasonable fee for the cost of producing and mailing the copies.

Notice Informing Individuals of Nondiscrimination and Accessibility

Health New England complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health New England does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health New England:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Susan O'Connor, Vice President and General Counsel.

If you believe that Health New England has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Susan O'Connor, Vice President and General Counsel, One Monarch Place, Suite 1500, Springfield, MA 01104-1500, Phone: (888) 270-0189, TTY: 711, Fax: (413) 233-2685 or ComplaintsAppeals@hne.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Susan O'Connor, Vice President and General Counsel is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Multi-Language Services

We're here to help you. We can give you information in other formats and different languages. All translation services are free to members. If you have questions regarding this document please call the toll-free member phone number listed on your health plan ID card, (TTY:711), Monday through Friday, 8:00 a.m.-6:00 p.m.

Last Reviewed: 7/31/2019

English	You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. (TTY: 711)
Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. (TTY: 711)
Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. (TTY: 711)
Chinese	您有權免費以您使用的語言獲得幫助和訊息。如需口譯員，請撥打您的保健計劃ID卡上列出的免費會員電話號碼，按0。(TTY: 711)

French Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. (TTY: 711)
Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. (TTY: 711).
Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия (телетайп: 711)
Arabic	يحق لك الحصول على المساعدة والمعلومات بلغتك مجانًا. لطلب مترجم، اتصل برقم هاتف العضو المجاني على بطاقة تعريف خطتك الصحية، ثم اضغط على 0. (TTY:711)
Mon-Khmer, Cambodian	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើមបីសនើសុំអ្នកបកប្រែ សូមទូរស័ពទៅលេខឥតគិតថ្លៃសំរាប់សមាជិក ឬលេខកត់ដៅកនុងប័ណ្ណ ID គំនរាងស ខភាពរបស់អ្នក រួចដ ើយ ើ 0។ (TTY: 711)
French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. (ATS: 711).
Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti (TTY: 711).
Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. (TTY: 711).
Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. (TTY: 711).
Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
Gujarati	તમારી ભાષામાં વિના મૂલ્યે મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયાની વિનંતી કરવા માટે તમારા હેલ્થ પ્લાન ID કાર્ડ પર જણાવેલા ટોલ-ફ્રી નંબર પર કૉલ કરો અને 0 દબાવો. (TTY: 711).
Lao	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫ ຼືອແລະຂ ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບ ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື ່ອຂ ຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສ າລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. (TTY: 711).
Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. (TTY: 711).
Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. (TTY: 711).

Health New England

One Monarch Place, Suite 1500
Springfield, MA 01144-1500
healthnewengland.org

WELLNESS REIMBURSEMENT FORM

There is more to staying healthy than seeing your doctor. It's up to you to make healthy choices. That's why Health New England gives you more than just coverage for your doctor visits. Health New England will reimburse you up to $200 per individual plan and $400 per family plan per calendar year towards services such as:*

- Aerobic/wellness classes
- Athletic event registration fees
- Bike shares
- Community supported agriculture (CSA) or farm shares
- Fitness equipment and devices (i.e., treadmill, workout videos, fitbit)
- Golf and ski tickets
- Mindfulness classes and apps
- Nutrition classes and apps
- Personal trainer fees
- Qualifying fitness club memberships
- School and town sports
- Weight Watchers®
- Wellness and fitness apps

Health New England will *not* reimburse you for:	
• Classes or personal training sessions with uncertified trainers	• Fees paid to weight loss programs other than Weight Watchers®
• Country clubs, social clubs or tanning salons	• Vitamins, supplements
• Fees paid for food (food source not from CSA), books, transportation, smartphones or smart watches, or any other items or services	• Kids' camps (i.e., art, bible, town, etc.). Will cover sports camps, if run by certified coaches/trainers.

Subscriber Information			
Last Name:	First Name:		
Street Address:	City:	State:	Zip:
Health New England ID #:	Telephone #:		
All reimbursements will be sent to the Subscriber's address currently on file with Health New England. Maximum reimbursement is $200 per individual plan and $400 per family plan per calendar year.*			

Member Information (Names of all covered family members for whom you are submitting this request)		
Member Name (Last, First)	Relationship to Subscriber	Date of Birth

Activity for Reimbursement				
Type of Activity	Program/Facility Name	Address/Phone #	Amount Requested	Calendar Year

Certification and Authorization. *(This form must be signed by each covered family member aged 18 or older for whom reimbursement is sought.)*

I authorize the release of any information to Health New England about my aerobic/wellness classes; athletic event registration fees; bike shares; CSA or farm share purchases; fitness equipment and devices; golf and ski tickets; mindfulness classes and apps; nutritional classes and apps; personal trainer fees; qualifying fitness club memberships; school and town sports registration; Weight Watchers® participation; and wellness and fitness apps. I certify that the information provided in support of this submission is complete and correct.

Subscriber/Member Signature: _____ Date: _____

Signature required for payment

Mail completed form to: Health New England, Claims Department, One Monarch Place, Suite 1500, Springfield, MA 01144-1500.

Please allow 4–6 weeks for processing. **NOTE:** Reimbursement requests for a prior year must be received by Health New England no later than March 31.

**Not all employer groups offer reimbursement for all items and activities listed. Not all employer groups offer this reimbursement amount. Reimbursement amount is valid beginning Jan. 1, 2019. Please check your membership materials for details, or contact Member Services if you need more information.*

COM 3756-0719_A

Health New England
Where you matter.

Authorization of Personal Representative Form Instructions

State and federal law gives you the right to choose one or more persons to act on your behalf with respect to the health information that pertains to you. By completing the Authorization of Personal Representative form, you are telling Health New England that you chose the named person as your Personal Representative. This form also allows Health New England to disclose your Protected Health Information (PHI) to the person you choose. The signature of a minor over the age of 12 is required to authorize release of sensitive information to their parent or legal guardian. (To authorize the release, the minor must complete Section 3 and sign this form.)

If you have questions about this form, call Member Services at **(413) 787-4004 or (800) 310-2835. Medicare Advantage members** should call **(413) 787-0010 or (877) 443-3314 (TTY 711).**

INSTRUCTIONS: Complete all sections of the form. Please type or print all responses. This form must be filled out completely to be valid.

Once completed, print and mail or fax the form to:
Health New England
Attention: Enrollment Department
One Monarch Place, Suite 1500, Springfield, MA 01144-1500 | Fax: (413) 233-2635

Please note: This form is available to print online at **healthnewengland.org/forms.**

Section 1. Provide the following Member identifying information

- ***Health New England Member ID# from your member ID card.***
- ***Medicare Number.*** Medicare members only, provide your Original Medicare # from the red, white and blue card.
- ***Name, Address, Telephone and Date of Birth of member.***

Section 2. Provide the following Personal Representative identifying information:

- ***Representative Name:*** Name of the individual you are authorizing to receive your PHI
- ***Address:*** Address of your Personal Representative
- ***Telephone:*** Telephone #s (home, cell and work) of your Personal Representative
- ***Relationship to Member:*** Personal Representative's relationship to the member (for example, parent, spouse, friend or attorney)

Section 3. Provide the Type of Information that may be disclosed and any date limitations.

- ***All Information:*** Check if authorizing all PHI to be shared with your Personal Representative except for Sensitive Health Information. (Please note that you still need to check the boxes for sharing any Sensitive Information if you wish to authorize release of this information.)
- ***Sensitive Health Information:*** Check the boxes for the types of information authorized if any. Please note: The signature of a minor over the age of 12 is required to authorize release of Sensitive Health Information to their parent or legal guardian in order for Health New England to disclose this information. (To authorize the release, the minor must complete this section and sign the form along with the parent/guardian to be valid.)
- ***Only the information specified (type(s)/date(s)):*** Provide the type(s) of information and any date ranges authorized. For example, you may authorize Health New England to share information about specific claims for specific dates of service.

Corp 4070-0320

Section 4. Provide the Purpose of the authorization.

- ***Any and all:*** Check if you are authorizing disclosure for any and all reasons. Your Personal Representative shall have all of the rights and privileges that you have with respect to your health information, including, but not limited to, requesting authorization on your behalf for certain services, changing your Primary Care Provider, discussing your eligibility, billing or claims information, and requesting copies of your records.
- ***Grievance/Appeal:*** Check if you are only authorizing disclosure to help with an appeal or grievance. Specify in Section 3 the type of information – for example, the name of the provider and the date(s) of the denied claim or authorization you wish to appeal. Such authorization shall include the right to view any documents, including medical records, related to this appeal.
- ***Other purpose (specify):*** Specify other specific reasons for disclosure, for example, to "Help with my bill." Again, be sure to include any limits on what you want to allow us to discuss.

Section 5. Review the Terms of the Authorization and specify the end date, if appropriate.
Health New England has a record retention period of ten (10) years.

- **For Medicare members**: Medicare allows Appointment of a Personal Representative effective for one (1) year and the personal representative must sign Section 8 of this form.
- **For Commercial members**: If you do not provide an end date, this authorization will be valid for ten (10) years from the date signed. If you wish to end the authorization sooner, you must send us written notice to end the authorization.
- To revoke the authorization, the Revocation of Authorization form is available to print online at **healthnewengland.org/forms.**

Section 6. Print, sign and date the form. (Please note: a minor over age 12 must sign the form here and complete Section 3 if the minor wishes to authorize a parent to receive Sensitive Information as noted above.)

Section 7. If the individual is a minor or is otherwise unable to sign (for example, due to incapacitation), the Personal Representative also needs to sign and complete this section. (If other than "parent," please attach documentation, such as court appointment, power of attorney, etc.)

Section 8. For Medicare Members Only
If you want your Personal Representative to file prior approval requests, claims, grievances or appeals on your behalf, your Personal Representative MUST complete this section and accept the appointment. Authorization to do these things is only valid for ONE YEAR from the date you sign the Authorization Form.

Health New England
Where you matter.
One Monarch Place, Suite 1500
Springfield, MA 01144-1500
healthnewengland.org

AUTHORIZATION OF PERSONAL REPRESENTATIVE FORM

1.	Member ID #:	(Health New England card #)		
	Medicare #:	(Original Medicare card # if applicable)		
	Member Name:			
	Home Address:			
	Home Telephone:		Date of Birth:	
2.	Representative Name:			
	Address:			
	Telephone:	Home:	Cell:	Work:
	Relationship to Member:			

3. Provide the Type of Information that may be disclosed and any date limitations.
I authorize Health New England to disclose the following health information to my Personal Representative:

☐ All non-sensitive health information

The following types of sensitive health information (check all that you authorize)*

☐ Abortion ☐ Alcohol/Substance Abuse ☐ Mental Health ☐ Pregnancy

☐ AIDS/HIV ☐ Genetic Testing ☐ Physical Abuse ☐ Sexually Transmitted Diseases

☐ **Only the information specified (type(s)/date(s)):**

**Members age 12 or older must specifically authorize each type of Sensitive Health Information that can be disclosed.*

4. **Purpose:** ☐ **Any and all** ☐ **Grievance/Appeal only** ☐ **Other**: *(Specify below)*

5. **Terms of this Authorization:**

- I understand that once my information is disclosed to my Personal Representative, Health New England cannot guarantee that my Personal Representative will not redisclose my health information to a third party, and that state and federal laws may no longer protect such information.
- I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Health New England's treatment of me, enrollment in the health plan, or eligibility for benefits.

Section 5 continues on next page

Corp 4070-0320

	• **For Medicare members:** I understand that this Authorization will remain in effect until the earliest of the following: _____ (date), or one (1) year from the member signature date, or until I provide written revocation notice to the address at the end of this form. • **For Commercial members:** I understand that this Authorization will remain in effect until the earliest of the following: _____ (date), or ten (10) years from the member signature date, or until I provide written revocation notice to the address at the end of this form. • The revocation will be effective immediately upon Health New England's receipt and processing of my written notice, except that the revocation will not have any effect on any action taken in reliance on my Authorization before Health New England received my written notice of its revocation.
6.	**I have read and understand the terms of this Authorization. I hereby, knowingly and voluntarily, authorize Health New England to use or disclose my information in the manner described above.** _____ _____ **Signature of Individual Authorizing Release of Health Information** **Date**
7.	**If Individual is a minor or is otherwise unable to sign, please sign and complete below. (If other than "parent," please attach documentation, such as court appointment, power of attorney, etc.)** _____ _____ _____ **Signature of Authorized Legal Guardian, Health Care Agent or other Personal Representative** **Relationship** **Date**
8.	**MEDICARE MEMBERS ONLY** **If you intend for your Personal Representative to be able to file (i) a request for prior approval, (ii) a claim, (iii) a grievance or (iv) an appeal on your behalf, your Personal Representative must complete this section.** **This Authorization is only effective for ONE YEAR from the date of the member's signature.** **Acceptance of Appointment (to be completed by the Personal Representative):** **I, _____, accept the above appointment.** **(Printed Name)** _____ _____ **(Signature)** **(Date)**

Once completed, print and mail or fax the form to:

Health New England
Attention: Enrollment Department
One Monarch Place, Suite 1500, Springfield, MA 01144-1500 | Fax: (413) 233-2635

OPTUMRx®

NEW PRESCRIPTION MAIL-IN ORDER FORM
Formulario de Pedido por Correo para Nuevas Recetas

1 **Member and physician information — please use black or blue ink. One form per member.**
Información sobre el miembro y el médico — use tinta negra o azul. Un formulario por miembro.

Member ID Number | *Número de Identificación del Miembro*		
(Additional coverage, if applicable | *Cobertura adicional, si corresponde*) Secondary Member ID Number | *N.º de Identificación del Miembro Secundario*		
Last Name | *Apellido*	First Name | *Nombre*	MI | *Inicial 2.do Nombre*
Delivery Address | *Dirección de Entrega*		Apt. # | *N.º de Apto.*
City | *Ciudad*	State | *Estado*	ZIP | *Código Postal*
Phone Number with Area Code | *Número de Teléfono con Código de Área*		
Date of Birth (mm/dd/yyyy) | *Fecha de Nacimiento (mm/dd/aaaa)*	Gender | *Sexo* O M O F	Email | *Correo Electrónico*
Physician Name | *Nombre del Médico*		
Physician Phone Number with Area Code | *Número de Teléfono del Médico con Código de Área*		

2 **Health history | *Historial médico***

Medication Allergies | *Alergias a Medicamentos*:
- O None known | *Ninguna conocida*
- O Amoxil/Ampicillin | *Amoxicilina/Ampicilina*
- O Aspirin | *Aspirina*
- O Cephalosporins | *Cefalosporinas*
- O Codeine | *Codeína*
- O Others | *Otros*: _____
- O Erythromycin | *Eritromicina*
- O NSAIDs | *NSAID*
- O Penicillin | *Penicilina*
- O Quinolones | *Quinolonas*
- O Sulfa | *Sulfamidas*
- O Tetracyclines | *Tetraciclinas*

Health Conditions | *Condiciones de Salud*:
- O None known | *Ninguna conocida*
- O Arthritis | *Artritis*
- O Asthma | *Asma*
- O Cancer | *Cáncer*
- O Diabetes | *Diabetes*
- O Others | *Otros*: _____
- O Glaucoma | *Glaucoma*
- O Heart condition | *Condición cardíaca*
- O High blood pressure | *Presión arterial alta*
- O High cholesterol | *Colesterol alto*
- O Osteoporosis | *Osteoporosis*
- O Thyroid Disease | *Enfermedad de la glándula tiroide*

Over-the-counter/herbal medications taken regularly | *Medicamentos a base de hierbas/de venta sin receta que toma regularmente*:

3 Payment and shipping information — do not send cash
Información de envío y pago — no envíe dinero en efectivo

Standard delivery is included at no charge. New prescriptions should arrive within about 10 business days from the date the completed order is received. Completed refill orders should arrive within about 7 business days. OptumRx will contact you if there will be an extended delay in delivering your medications. | *El envío estándar está incluido sin cargo. Las nuevas recetas deberían llegarle dentro de los 10 días hábiles aproximadamente a partir de la fecha de recepción del formulario de pedido llenado. Los pedidos de resurtidos deberían llegarle dentro de los 7 días hábiles aproximadamente. OptumRx se comunicará con usted si hay una demora prolongada en la entrega de sus medicamentos.*

You may log on to the member website to see if drug pricing information is available before enclosing payment. Once shipped, medications may not be returned for a refund or adjustment. | *Puede iniciar sesión en el sitio de Internet para miembros para ver si hay información sobre el precio de los medicamentos antes de adjuntar el pago. Una vez que los medicamentos se envían, no se aceptan devoluciones para obtener un reembolso o ajuste.*

- ○ **Ship overnight.** Add $12.50 to order amount (subject to change).
  Servicio de mensajería con entrega en 24 horas. *Agregue $12.50 al monto del pedido (sujeto a cambio).*
- ○ **Check enclosed.** All checks must be signed and made payable to: OptumRx.
  Cheque adjunto. Todos los cheques deben estar firmados y ser pagaderos a la orden de: OptumRx.
- ○ **Charge to my credit card on file. | *Cargo a la tarjeta de crédito que figura en archivo.***
- ○ **Charge to my NEW credit card. | *Cargo a mi NUEVA tarjeta de crédito.***

New Credit Card Number | *Número de Nueva Tarjeta de Crédito*

Expiration Date (Month/Year) | *Fecha de Vencimiento (Mes/Año)*

Visa, MasterCard, AMEX and Discover are accepted. | *Se aceptan tarjetas Visa, MasterCard, AMEX y Discover.*

Signature | *Firma*: _____ **Date | *Fecha*:** _____

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, **I authorize OptumRx to maintain my credit card on file as payment method for any future charges.** To modify payment selection, contact customer service at any time. | *En el caso de pedidos de nuevas recetas y resurtidos de mantenimiento, se facturará a esta tarjeta de crédito el copago/coaseguro y otros gastos relacionados con los pedidos de recetas. Al proporcionar mi número de tarjeta de crédito,* ***autorizo a OptumRx a que conserve la información de mi tarjeta de crédito en sus registros como método de pago para cualquier cargo futuro.*** *Para modificar la selección de pago, comuníquese con el servicio al cliente en cualquier momento.*

4 Mail this completed order form with your new prescription(s) to |
Llene y envíe este formulario de pedido junto con sus nuevas recetas a:

OptumRx, P.O. Box 2975, Mission, KS 66201

DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM. |
NO ENGRAPE NI PEGUE CON CINTA RECETAS EN ESTE FORMULARIO DE PEDIDO.

Health New England

One Monarch Place, Suite 1500
Springfield, MA 01144-1500
healthnewengland.org

SMOKING CESSATION CLASS/HYPNOSIS REIMBURSEMENT FORM

Health New England is behind you in your efforts to become and remain smoke-free. In fact, we believe very strongly that quitting smoking will improve your quality of life and overall health. That is why Health New England will pay you up to $50 for attending a smoking cessation class or hypnosis session.

REQUIREMENTS

- The participant in the program must be an active Health New England member at the time of participation.
- You can submit your form once per calendar year.
- Receipts and documents will not be returned. Health New England will accept copies of receipts.
- Instructors must sign this form as proof of class completion.

SUBSCRIBER'S INFORMATION

LAST NAME	FIRST NAME	
STREET ADDRESS	STATE	ZIP
EMPLOYER'S NAME	HEALTH NEW ENGLAND ID #	PHONE #

All reimbursements will be sent to the subscriber's address currently on file with Health New England.
Maximum reimbursement is $50 per member per calendar year.

MEMBER'S INFORMATION

LAST NAME	FIRST NAME
RELATIONSHIP TO THE SUBSCRIBER	DATE OF BIRTH / /
CLASS DATE/LOCATION	PROGRAM/FACILITY NAME
CLASS INSTRUCTOR NAME	CLASS INSTRUCTOR PHONE #

INSTRUCTOR SIGNATURE X	DATE
SUBSCRIBER/MEMBER SIGNATURE	DATE

Please submit this form and all documentation to:
Health New England - Member Reimbursements
One Monarch Place, Suite 1500
Springfield, MA 01144-1500
Please allow 4–6 weeks for processing.
Note: Reimbursement requests for the prior year must be recieved by Health New England no later than March 31.

FOR HEALTH NEW ENGLAND USE ONLY

EFFECTIVE DATE	GROUP #
PAID DATE	CHECK #

#@@@#=PERF

CORP 2393-0416
Rev 3/19

Health New England

One Monarch Place, Suite 1500
Springfield, MA 01144-1500
healthnewengland.org

SMOKING CESSATION CLASS/HYPNOSIS REIMBURSEMENT FORM

WESTERN MASSACHUSETTS SMOKING CESSATION PROGRAMS

Caring Health Center Springfield, MA	*Tobacco Treatment Services* **(413) 739-1100**
Holyoke Medical Center Holyoke, MA	*Quit Smoking Workshop* **(413) 534-2789**
Berkshire Medical Center Pittsfield, MA	*Tobacco Treatment Services* **(413) 447-2715**
Fairview Medical Center Pittsfield, MA	*Quit Now at Fairview Medical Center* **(413) 854-9622**

ONLINE RESOURCES

Make Smoking History (free for Massachusetts residents)	*makesmokinghistory.org* **(800) 784-8669 or 1-800-QUIT-NOW**
American Lung Association *Freedom from Smoking*	*ffsonline.org* **(413) 737-3506 or 1-800-LUNGUSA**
Quit All Together	*quitnet.com*

ADDITIONAL BENEFIT INFORMATION

Many smoking cessation programs recommend the use of nicotine replacement therapies to supplement and support your efforts. Your doctor (obstetrician, if you are pregnant) should decide if these are safe options for you. Depending on your Health New England insurance policy, if you are enrolled in a smoking cessation program, you may be eligible to get these medications for a limited time at $0 cost-share. (Individual coverage/copays vary by employer group.)

Check Health New England's Prescription Formulary on healthnewengland.org and with your Benefits Administrator for possible coverage of the following:

- Nicotine Replacement Gum, Lozenge or Patch
- Nicotrol® nasal spray
- Nicotrol® inhaler
- Chantix
- Generic Zyban® (bupropion SR)

Note: These medications, if covered, have a maximum allowable number of doses per prescription and refills. Please call Health New England Member Services for updated information or if you have questions at ***(413) 787-4004*** *or* ***(800) 310-2835****, Monday–Friday, 8 a.m.– 6 p.m.*

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Health New England
One Monarch Place, Suite 1500
Springfield, MA 01144-1500
healthnewengland.org
Phone: (413) 787-4000 | (800) 842-4464 | Enrollment Fax (413) 233-2635

ENROLLMENT/ADD/TERMINATION FORM

PLEASE PRINT AND/OR TYPE INFORMATION. PRINT TO SIGN.

TYPE OF PLAN: ☐ HMO ☐ PPO ☐ GROUP MEDICARE SUPPLEMENT

EMPLOYEE NAME (FIRST, LAST)	COMPANY NAME	PLAN
PRIMARY CARE PROVIDER (PCP) (REQUIRED FOR HMO PLANS)	(PCP) PROVIDER ID# (REQUIRED FOR HMO PLANS)	IS THIS YOUR DOCTOR NOW? ☐ YES ☐ NO
SS# (REQUIRED)	DOB MONTH DAY YEAR	GENDER ☐ MALE ☐ FEMALE
ADDRESS STREET	APT NO.	P.O. BOX
CITY STATE	ZIP	
TELEPHONE (HOME) ( )	TELEPHONE (WORK) ( )	EMAIL
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER	PRIMARY LANGUAGE SPOKEN	
ETHNICITY (use codes from back of form) 1ST	2ND	OTHER / RACE (Use codes from back of form)

WILL ANYONE COVERED ON THIS POLICY KEEP OTHER HEALTH INSURANCE? ☐ YES ☐ NO

NAME OF INSURANCE CO. _____ POLICY #_____

NAMES OF COVERED INDIVIDUALS _____

IS EMPLOYEE RETIRED? ☐ YES RETIREMENT DATE _____ ☐ NO

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY MEDICARE?* ☐ YES ☐ NO

IF YES, ☐ PART A ☐ PART B INCLUDE COPY OF MEDICARE CARD

MEDICARE CLAIM # _____

**If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.*

FOR GROUP MEDICARE SUPPLEMENT MEMBERS: WILL THIS POLICY REPLACE ANY OTHER ACCIDENT AND SICKNESS INSURANCE CURRENTLY IN FORCE? ☐ YES ☐ NO

DEPENDENT NAME(S) FIRST LAST (IF NOT SAME AS EMPLOYEE)	ETHNICITY (SEE REVERSE)	RACE (SEE REVERSE)	LANGUAGE (SEE REVERSE)	DATE OF BIRTH MO DAY YR	GENDER		SOCIAL SECURITY # (REQUIRED)	PCP NAME (REQUIRED FOR HMO PLANS) FIRST LAST	PROVIDER ID#	IS THIS YOUR DOCTOR NOW?	
☐ SPOUSE ☐ OTHER				- -	M	F	- -			Y	N
				- -	M	F	- -			Y	N
				- -	M	F	- -			Y	N
				- -	M	F	- -			Y	N

71

I UNDERSTAND THAT BY ACCEPTING COVERAGE UNDER THIS PLAN, HEALTH NEW ENGLAND AND ANY HEALTH CARE PROVIDER MAY RECEIVE, USE AND DISCLOSE MY MEDICAL INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND ANY AND ALL OTHER USES ALLOWED BY LAW. I HAVE READ AND UNDERSTAND THE TERMS OF ENROLLMENT ON THE BACK OF THIS FORM. I CERTIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Ⓧ _____
EMPLOYEE SIGNATURE DATE

BELOW SECTION TO BE COMPLETED BY EMPLOYER

EFFECTIVE DATE _____ (new enroll choose qualifying event below)

☐ **NEW ENROLLMENT** ☐ **ADD DEPENDENT** ☐ **CHANGE MEMBER INFO**

CHOOSE REASON:

☐ **NEW HIRE** (DATE OF HIRE REQUIRED) ☐ **LOSS OF INSURANCE** ☐ **ANNUAL OE** **OTHER** _____ (SPECIFY)

☐ **TRANSFER TO COBRA**

CHOOSE ONE: ☐ **HNE COBRA** ☐ **HNE COBRA WITH HEALTH EQUITY HRA**

DATE OF HIRE: _____ **HNE GROUP #:** ☐☐☐☐☐☐ — ☐☐☐☐

☐ **TERM POLICY** ☐ **TERM DEPENDENT** **END DATE** _____

CHOOSE REASON:

☐ **LEFT EMPLOYMENT** ☐ **MOVED** ☐ **VOLUNTARY CANCEL**

☐ **COBRA TERM** ☐ **NO LONGER ELIGIBLE** ☐ **DECEASED**

TYPE OF COVERAGE: ☐ **INDIVIDUAL** ☐ **FAMILY** ☐ **EE+1** ☐ **OTHER**

Ⓧ _____
EMPLOYER SIGNATURE DATE

IMPORTANT: PLEASE READ THESE TERMS OF ENROLLMENT

As an employee, I understand that:

1. By submitting this form or accepting coverage under the plan, I agree, on behalf of myself and all enrolled dependents, to abide by the terms of the Health New England (HNE) Agreement, which includes this form as well as the applicable Explanation of Coverage or Summary Plan Description.

2. Membership will become effective upon acceptance by the Plan and that benefits under the Plan will be explained in a separate document (Explanation of Coverage or Summary Plan Description).

3. I may only enroll dependents subject to the guidelines outlined in my HNE Agreement.

4. Whenever I seek treatment or services, I must identify myself as an HNE member by presenting my HNE Identification Card.

5. I must select a Primary Care Physician for myself and my dependents (does not apply to PPO).

6. If appropriate, I authorize my employer to deduct from my wages the rate required for the coverage selected.

As an employer, I understand that:

1. **By submitting this form, I certify that the information provided on this form is accurate.**

RACE & ETHNICITY

Why are these questions being asked?

The Commonwealth of Massachusetts has established statewide goals for improving health care quality and reducing racial and ethnic disparities in health care. HNE wants to do our part to remove any barriers to fair and unbiased treatment for all of our members. By collecting information about your race and ethnic background, we may be able to identify possible issues that affect the care or treatment you receive. HNE will then be able to work with our provider community to address any issues. We appreciate your assistance in this effort.

This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment. HNE keeps this information confidential according to our policies and state and federal law.

RACE Please choose from the following:
Fill in the code where indicated on the front of this form.

Code	Description
R1	American Indian/Alaska Native
R2	Asian
R3	Black/African American
R4	Native Hawaiian or other Pacific Islander
R5	White
R9	Other Race
UNKNOWN	Unknown/not specified

ETHNIC GROUP Please choose from the following: you may choose more than one. Fill in the code where indicated on the front of this form.

Code	Description
2182-4	Cuban
2184-0	Dominican
2148-5	Mexican, Mexican American, Chicano
2180-8	Puerto Rican
2161-8	Salvadoran
2155-0	Central American (not otherwise specified)
2165-9	South American (not otherwise specified)
2060-2	African
2058-6	African American
AMERCN	American
2028-9	Asian
2029-7	Asian Indian
BRAZIL	Brazilian
2033-9	Cambodian
CVERDN	Cape Verdean
CARIBI	Caribbean Island
2034-7	Chinese
2169-1	Columbian
2108-9	European
2036-2	Filipino
2157-6	Guatemalan
2071-9	Haitian
2158-4	Honduran
2039-6	Japanese
2040-4	Korean
2041-2	Laotian
2118-8	Middle Eastern
PORTUG	Portuguese
RUSSIA	Russian
EASTEU	Eastern European
2047-9	Vietnamese
OTHER	Other Ethnicity
UNKNOWN	Unknown/not specified

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